

COMMENTS REGARDING PROPOSED MENTAL LISTING REVISIONS

This is a brief outline of my concerns. I would be willing to discuss my comments in further detail or provide more detailed recommendations. Please do not hesitate to contact me. I would like to also emphasize the opinions expressed above are my own and do not necessarily reflect the opinions of the Kansas DDS.

Adult Claims:

1. I would favor granting temporary disability benefits. Many claimant's who meet the duration requirement will likely not be permanently disabled. The current CDR requirements of medical improvement make the likelihood of ceasing benefits extremely low. In my view, it would be preferable to offer limited-term disability (i.e., one, three or five years). The claimant could then reapply for benefits. The claimant could have the option of continuing their benefits until all of their appeal options had been exhausted.
2. For some claimants, a partial disability award makes sense. They have a reduced capacity for employment, but their disability does not preclude part-time employment. The current SGA levels is not sufficient for a claimant to be self-supporting. Offering the claimant the opportunity to apply for partial disability (i.e., 25% or 50%), would be an employment incentive. My experience is that employment is therapeutic for a great number of individuals with psychiatric impairments.
3. Treatment and rehabilitation should be tied to receiving disability benefits when appropriate. Many claimants who could benefit from treatment do not seek treatment. The current system provides a "disincentive for getting better." A claimant that could reasonably benefit from treatment should be required to seek treatment in order to receive disability benefits.
4. The possibility of granting a medical assistance only benefit makes sense. There are claimants that could work with proper treatment but do not have sufficient resources to obtain appropriate treatment. For these clients, Medicaid coverage but not cash benefits would be appropriate.
5. The current mental residual functional capacity assessment (MRFC) is problematic because the terms "moderate" and "marked" are highly subjective and poorly defined. Also, many of the 20 listed items on the MRFC are not well defined. The typical disability case file does not contain enough information to reliably or validly rate many of the MRFC items. I would recommend adopting a four-tier ranking system similar to what is utilized on the physical RFC. The four broad categories in the MRFC (understanding and remembering, sustained concentration and persistence, social interaction, and adaptation) could be rated on a four-point scale that is tied to a specific behavioral example. (e.g. maintain attention and concentration for 1) less than 5 minutes; 2) for 5 to 30 minutes; 3) for 30 minutes to one hour; 4) for more than one hour). The combination of ratings in all four broad categories would be tied to a specific level of functioning. Currently, the interpretations of the ratings on the MRFC vary widely.

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6. There appears to be an over-reliance on single mental status examinations and standardized testing to determine disability. Extended observations and comprehensive work evaluations would provide a much more complete picture of the claimant's actual functioning.

CHILDHOOD DISABILITY CLAIMS

1. The concept of unrestricted disability income for children appears to be flawed. The purpose of disability income is to replace lost wages. This, of course, is not the case for children. From my perspective, it only makes sense to offer parents cash benefits if they can clearly demonstrate specific increased costs associated with their child's disability. Assuming this is equally applicable to all childhood disabilities does not make sense. I believe that parents should specify their increased costs and apply for specific reimbursement.
2. I believe the concept of a medical assistance only disability benefit also would be appropriate for childhood claims.
3. The current method for determining childhood disability seems problematic. Granting disability based on an "extreme" limitation in any one domain or "marked" limitations in any two domains is problematic because this assumes that each domain is equally critical in determining age-appropriate functioning. This system is also based on the assumption that all of the domains are independent from each other and, therefore, can be added together to make a disability determination. I do not believe that the issue of "double weighting" has ever been adequately resolved. Finally, the degree of impairment that corresponds to a "marked" or "extreme" impairment rating does not seem equivalent for all six domains. The level of impairment that is necessary to obtain a "marked" limitation in moving about and manipulating objects may be much more severe than a level of impairment needed to obtain a "marked" limitation in the domain of interacting and relating to others.

I believe a better option would be to define childhood disability in terms of specific restrictions in age-appropriate activities and the need for supported services, treatment and assistive technology.

Sincerely,



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